Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2774AGZ	A. BUILDING _____ B. WING _____	10/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR HOME CARE - STARBUCK 2	1813 STARBUCK DR LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of the Annual Survey conducted at your facility October 10, 2008. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed as a 4 bed Residential Facility for Groups, which provides care to elderly and disabled persons, and persons with Alzheimer's disease, Category II residents. The census was 1 resident . One (1) discharged file was reviewed. One (1) resident's file was reviewed. Two (2) employee files were reviewed. No deficiencies were identified during the survey. No further action is necessary concerning this report. Please retain this copy for your records.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE